CIGNA HealthCare
of Arizona, Inc.
A Business of Caring.

Authorization for the Disclosure of Protected Health Information

I, the undersigned, understand and agree to the following:

1. I have voluntarily scheduled my Biometric Health Screening and/or Nicotine Saliva Test appointment. I understand that I am not under any obligation to sign this Authorization, complete the attached Personal Health History Questionnaire (Questionnaire), or schedule or undergo the Biometric Health Screening or Nicotine Saliva Test, as a condition of enrollment, eligibility for benefits, treatment, payment or coverage under the Maricopa County medical plan. However, I understand that my refusal to sign this Authorization, fully complete the Personal Health Questionnaire (Questionnaire) and fully complete each of the Biometric Health Screening measures or Nicotine Saliva Test disqualifies me for any employee contribution reduction related to my medical plan coverage through Maricopa County.

2. I understand that Maricopa County has arranged for Connecticut General Life Insurance Company (CGLIC), which administers the Maricopa County medical plan, its affiliate CIGNA HealthCare of Arizona, Inc. (CIGNA HealthCare) and CIGNA HealthCare vendor, CIGNA Onsite Health, LLC to provide or arrange for the scheduling and conduct the Biometric Health Screening and Nicotine Saliva Test and to receive the results and review my responses to the Questionnaire and use and disclose the information as described below.

3. I consent to each of the following testing and/or measurements in connection with my Biometric Health Screening and/or Nicotine Saliva Test appointment: nicotine saliva test, blood pressure, body composition analysis that includes height, weight, Body Mass Index (BMI), waist measurement, percent body fat, and a blood sample for the purpose of measuring my Total Cholesterol, HDL Cholesterol, calculated risk ratio, and/or Glucose levels.

4. I understand that I am entitled to receive a copy of this Authorization, the Questionnaire and my Biometric Health Screening Test results at the end of the appointment.

I authorize CIGNA HealthCare and/or CIGNA Onsite Health to use and disclose my Protected Health Information as authorized by law and specifically for the following purposes:

CIGNA HealthCare and/or CIGNA Onsite Health may disclose my name, employee ID number and test results to Maricopa County to assure that I receive the reduction in medical plan contributions to which I am entitled.

a. CIGNA Onsite Health may disclose my Biometric Health Screening test results and information provided on my Questionnaire to CGLIC and CIGNA HealthCare for its use in connection with administration of the Maricopa County medical plan and for its own health care operations.

b. CIGNA HealthCare and/or CIGNA Onsite Health may disclose my name and contact information, certain Biometric Health Screening test results related to me and my Questionnaire responses to Magellan Behavioral Health (Magellan). Magellan is contracted with Maricopa County to provide behavioral health and health coaching services. I understand that Magellan may reach out to me to determine my interest in participating in health coaching services.

I authorize the release of information from the Questionnaire, Biometric Screening and Nicotine Saliva Test in accordance with the provisions above, including the following information: BEHAVIORAL / MENTAL HEALTH INFORMATION (A.R.S. § 12-2291 *et seq.*).

I hereby release Maricopa County, CGLIC, CIGNA HealthCare, CIGNA Onsite Health, and Magellan, and their affiliates, directors, officers, employees, agents and contractors and any other organization(s) associated with this Biometric Health Screening, and this Questionnaire, together with their successors and assigns, from any liability arising from or in any way connected with my participation in the Biometric Health Screening and the Questionnaire or from the data derived therefrom.

I understand that: I may revoke this Authorization at any time by providing written notice to all entities listed in this Authorization; any information released in reliance on this Authorization and prior to such revocation shall not constitute a breach of my right to confidentiality; if this information is disclosed to a third party, the information may no longer be protected and may be redisclosed by the person or organization who receives the information. This Authorization will expire upon the later of the completion of follow-up on issues raised by the Questionnaire and Biometric Health Screening test results or one year from the date of its execution.

I understand that:

The data derived from these test(s) are considered to be preliminary; they are screening assessments only. They do not constitute any diagnosis and are for health information purposes only.

The responsibility for initiating a follow-up examination to confirm the results of this screening and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with this screening and/or health fair/event.

The chemical analyzer used to determine plasma glucose and serum lipid levels may yield results that are at variance from those produced by standard reference laboratory analyzers.

Signature: Date:_____ Date of Birth:_____

Last Name:_____ First Name:_____ Employee ID#:_____

Screening Location:_____ Employer Group: **Maricopa County**

Revised March 11, 2011